Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Full Council
Summary of Meeting Minutes
February 5, 2019

Call to Order and Roll Call

Gerd called the roll call at 1:02 P.M. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met. It was noted that this was the fifth Full Council meeting in a row where quorum was not met. Members stated that the continued failure to meet quorum should be addressed in some fashion.

Approval of Previous Full Council Minutes

A vote to approve the meeting minutes of *February 19, 2018*, *May 3, 2018*, *August 9, 2018, and November 8, 2018* could not be taken because quorum was not met.

New DHS Branding

Matt Highland discussed the new Department of Human Services (DHS) branding and how this change will impact forms, documents, and websites. In addition to the new color palette there will be significant improvements in navigation and website design on all DHS websites.

Data Recommendations Subcommittee Update

The 2018 Legislature directed the MAAC Executive Committee to review the code required reporting that is laid out in Iowa law and reported quarterly. The final report was submitted back to the legislature in time for the December 31, 2018 deadline. Gerd recognized the hard work that the subcommittee of the Executive Committee put into the report. It was noted that the document included in the materials was a draft copy from December 1, 2018. A final version of the document will be sent out to all council members.

Long-Term Care (LTC) Ombudsman Update

Cynthia Pederson gave an update on the LTC Ombudsman Year 3 Quarter 3 report including service reductions, advocacy, health and disability and intellectual disability waivers, issues affecting members in CDAC and CCO, Level of Care assessments, case management issues, Notice of Decision issues with MCOs, and network adequacy.

Medicaid Director's Update

Process Improvement Working Group

February of 2018 a work group of providers and parents was formed to discuss issues and challenges and opportunities within the Managed Care program. In the first meeting roughly one hundred and fifty issues were gathered, these issues were organized into themes. Subgroups were organized to work around specific themes. The overall group has identified three high-level themes: a.) providing annual and quarterly training, b.) streamlining of processes and c.) improving communications. The group has worked with the MCO's to eliminate unnecessary prior authorizations; thus far they have removed 200. A list of the removed prior authorizations will be published on the Iowa Medicaid Enterprise website. The

removal of these prior authorizations will be consistent across all three MCO's and across Medicaid as a whole.

MCO Contracts
CMS has approved Amendment 7; Amendment 8 is still being negotiated with the MCO's. Two weeks ago Mike implemented a weekly project meeting with the plan president of Iowa Total Care so that decisions and progress can be made at least every Wednesday. Iowa Total Care is continuing to build their provider network. Provider contracts are due back to Iowa Total Care by February 15, 2019. Mike provided an update on the status of adding Iowa Total Care to the program and the plan to redistribute members across the three MCOs based on an algorithm. Mike advised that some populations would not be included in the redistribution such as pregnant women and members who are seriously ill. Once a member is assigned to a new MCO members will have a 60 day choice period to change their MCO for any reason prior to implementation and an additional 90 days following implementation.

Rate Setting
Mike reviewed the PowerPoint document made available in the materials packet. The Centers for Medicare & Medicaid Services (CMS) must approve rates before a Medicaid program can move forward with a contract between the state and an MCO. The Office of the Actuary within CMS evaluates rates to ensure that rates comply with all federal and state laws. Iowa's rates are generally evaluated on an annual basis; however, events such as the inclusion of Iowa Total Care can result in a review by CMS. To be approved, rates must be considered actuarially sound.

2019 Annual Provider Training
Annual provider training will take place in 9 cities across Iowa starting May 13, 2019.The full schedule will be distributed to MAAC council members. Director Randol will attend three sessions.

Quarterly Managed Care Report
Liz Matney presented the Quarterly Performance Report for Quarter 1 SFY 2019 made available in the materials packet. Topics discussed included Plan Enrollment, the Appeals process, Program Management Reporting, Provider Helpline Metrics, Utilization of Value-Added Services, Capitation Payments Made to MCO's, Third Party Liability (TPL) Recovery, Fraud Waste and Abuse in regard to Program Integrity, and Health Care Outcomes.

Value Added Services Follow Up From November 20, 2019 Executive Committee Meeting

It was noted that Value Added services have been a regular topic of discussion, and Mike requested specific questions about this topic. Gerd stated that the table displayed in the quarterly report has been changed and there is some confusion around this data. Mike replied that the next edition will show a much larger list of value added services as the current one rolls up services into categories, and that seems to be where a lot of the confusion is coming from. Lori Allen asked how MCO's are paid for value added services, are they based on a person's diagnosis, or is there a fee that is set for that person per month. Mike stated that MCO's are paid on a per-member-per-month capitated payment. They are required to pay for all services for that member. The rate is based on 56 different rate cells, or cohorts, so each member could fall into one of 56 categories. The MCO's

receive a payment that totals each member in each of these categories each month. Value added services are not included in the capitated rate, and are services that the state does not require. Lori then asked who is monitoring what the rate is per person, does the state of Iowa determine what those rates are for those individuals. Mike stated that the State, specifically Mike personally, and the actuary monitor these rates and payments closely.

Updates from MCOs

Amerigroup Iowa, Inc.

John McCauly provided operational updates for Amerigroup. Amerigroup has implemented program changes that resulted from the last legislative session, including new program rules and cost initiatives. AmeriGroup has expanded mental health core services following last year's important mental health reform bill, including new services such as assertive community treatment. The IME Process Improvement Work Group has been a big focus for AmeriGroup, yielding results in the areas of provider reimbursement, clinical processes, and identification of opportunities for administrative simplification. AmeriGroup has successfully gone through provider re-contracting and renewal, incorporating a switch to value based contracting. John also provided a report on the activities of the Anthem foundation.

UnitedHealthcare Plan of the River Valley, Inc.

Paige Pettit gave an update on UnitedHealthcare. UHC has named former CFO Alissa Weber, as their new CEO. UHC continues to search for a new CFO to replace Alissa. UHC is preparing for the 2019 Annual Provider Training, and has updated several materials and forms on their website: CDAC form, Care Coordination Quick Reference Guide.

Iowa Total Care

Chris Priest (interim CEO of Iowa Total Care) introduced the Managed Care Organization, noting that it is a subsidiary of Centene Corporation which is one of the largest Managed Care providers in the country. Chris highlighted Centene's experience in standing up new MCO operations, as well as their commitment to keeping their operations local.

Secret Shopper Data

Gerd asked Paige Pettit to discuss how MCO's use the secret shopper data provided by the quarterly report. Paige stated that UHC receiveS a report from the IME, and then a quality team discusses the data: they identify opportunities and issues presented by the data. They then take these issues and opportunities to their frontline staff. Liz Matney stated that IME provides fairly granular data to the MCO, including date and time and identity of the call center representative. The IME and the MCO then have a discussion about the call. John McCauly stated that AmeriGroup's process is very similar to UHC. Each MCO call center is called a certain number of times with the same questions.

Comments For MCO's

Amy Shriver, public member and pediatrician, praised John McCauly's update on AmeriGroup, she also called for more of a distinction in these reports between child and adult lives, especially when it comes to mental health initiatives.

David Beeman was curious as to why he's seen some members have been directed to apply for disability by their MCO. Liz Matney responded stating this is a result of enhanced

care coordination. Care coordinators have been coached to advise the members they work with to apply for as much assistance as possible to ensure that the members needs are met. David then went on to request that the MCO's develop a closer relationship with the case workers who work in the Child Abuse division of DHS. John McCauly and Liz Matney responded asking for the information of the social workers in question so they could develop those connections.

Sue Whitty made a comment calling for more surveying of specific populations within Medicaid that have been affected by recent policy and spending changes, specifically youth with high needs. She commented that she appreciated the new formatting of the quarterly report. Liz stated that some of this work is being done already, and that some of these results are available in the quarterly report.

Open Discussion

Gerd recognized David Beeman who had submitted a question for discussion by email. David was concerned about the process by which CPT codes are changed. He stated that CMS has issued new CPT codes, specifically for psychology billing, on January 1, 2019. He contacted the MCO's about these new codes but they stated that they have not yet been implemented because the new codes must come through IME first. His concern is that the delay in implementing these codes will cause issues for members, as it is unclear to him whether or not a provider can bill for a service under the old codes while the new codes are being processed by IME. The uncertainty of whether or not codes can be billed to MCO's affects providers' ability to provide services. Director Randol clarified that there is a process, and that the IME has to change and update thousands of CPT codes quarterly and annually. The codes in question were just recently approved and will be communicated to MCO's and providers in the next several weeks. Furthermore, these codes and billing rates will be consistent across all MCO's. Director Randol stated that during the code change process a provider can continue to bill in the same manner. A member stated that she was concerned that Program Integrity might consider billing using the old codes as an example of fraud, and requested that there be some sort of paper trail that providers can use to mitigate this risk.

Steve Bowen made a comment regarding Iowa Telehealth, stating that providers should be reimbursed the same whether they provide services in person or via telehealth.

Barb Nebel asked about the progress of a State Plan Amendment regarding Multiple Procedure Payment Reduction (MPPR) for Speech, Occupational, and Physical Therapists, specifically if the open comment period was over. Director Randol stated that this period ended roughly one week ago, and the department is in the process of summarizing these comments and will be submitting the State Plan Amendment to CMS before the end of February. Steve Bowen asked for clarification of whether most of the comments received during the open comment period were for or against MPPR. Director Randol stated that they were against, but that MPPR would be implemented, and that this is not a new practice in the state of Iowa. Barb Nebel asked a follow up question, about whether the actual comments received during the open comment period would be directly forwarded on to

CMS. Director Randol stated that a summary would be forwarded and not the actual comments.

David Beeman returned to his question asking for clarification on the rate setting process in regards to these specific codes. Director Randol stated that he would send David a response outlining the process at a high level.

Barb Nebel asked a question regarding the Medicaid Reimbursement Comparison Report, specifically about where the rates were in the report for speech pathologists. Director Randol clarified that in order for the report to be comprehensible comparisons had to be rolled up into larger groups, but that individual comparisons could be found online. In a follow-up question Barb asked about the benchmark by which IME sets the rates, assuming that all of the reimbursement rates are below Medicare levels. Director Randol stated that it is inaccurate to assume all reimbursement rates are below Medicare levels, they may be above, at, or below Medicare.

Adjournment

Meeting adjourned at 4:03 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
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